



Maltreatment of Youth in U.S. Juvenile Corrections Facilities

AN UPDATE

THE ANNIE E. CASEY FOUNDATION

About the Author: This report was written by Richard A. Mendel, an independent writer and researcher.

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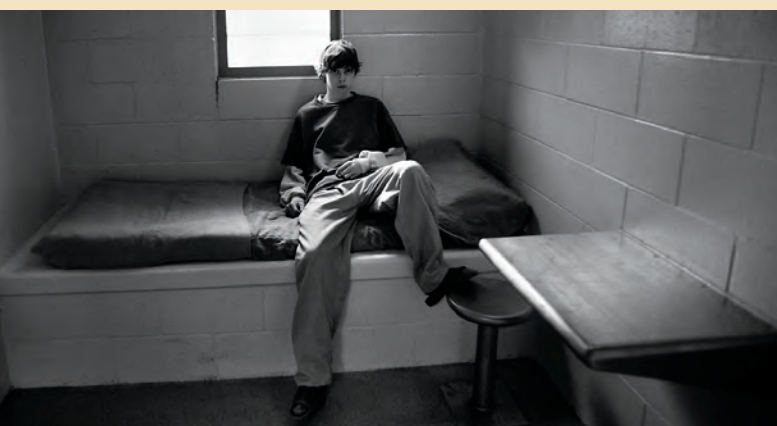
Table of Contents

Introduction and Summary	2
I. Findings from <i>No Place for Kids</i> on the Nature, Breadth and Extent of Maltreatment and Abuse in Juvenile Corrections Facilities	6
II. New Information About Maltreatment in State-Funded Juvenile Corrections Facilities	10
A. Additional States with Proven Maltreatment	10
B. Recidivist States	16
C. New Evidence of and Attention to Maltreatment	23
Conclusion	29
Endnotes	30

Introduction and Summary

In its 2011 report, *No Place for Kids: The Case for Reducing Juvenile Incarceration*, the Annie E. Casey Foundation demonstrated that America's heavy reliance on juvenile incarceration is a failed strategy for addressing youth crime.

Specifically, *No Place for Kids* showed that heavy reliance on correctional confinement exposes incarcerated youth to widespread maltreatment; results in alarming levels of recidivism; incarcerates children who do not pose significant threats to public safety; ignores the emergence of treatment models that produce better outcomes; wastes money with costs that often exceed \$100,000 per young person per year; and fails to provide adequate mental health, educational,



substance abuse and other services. In short, the report found that these institutions are dangerous, ineffective, unnecessary, obsolete, wasteful and inadequate.

This report focuses on the first of these challenges, the widespread and persistent maltreatment of youth confined in America's juvenile

corrections facilities. These facilities often go by euphemistic labels such as training school, reformatory, correctional center, etc., but are in essence youth prisons. In *No Place for Kids*, the Casey Foundation found that clear evidence of recurring or systemic maltreatment had been identified in the vast majority of states since 1970. In nearly half the states, this clear record of systemic maltreatment had been documented in juvenile correctional facilities since 2000. *No Place for Kids* also identified 52 lawsuits since 1970 that resulted in a court-sanctioned remedy in response to allegations of systemic problems with violence, physical or sexual abuse by facility staff and/or excessive use of isolation or physical restraints.

The following pages update those findings, and the news is not good. Rather, in the nearly four years since *No Place for Kids* was published, a flood of new revelations of abuse and maltreatment has emerged.

Proof of Pervasive or Ongoing Maltreatment in 14 States Since 2011, Plus Substantial Evidence (but No Concrete Proof) in Seven More States

More specifically, this report finds:

■ At the time of *No Place for Kids*' publication in 2011, no clear recent evidence of recurring or systemic maltreatment was available in Colorado, Georgia, Idaho, Illinois, Iowa, Tennessee or West Virginia. However, subsequent revelations have documented widespread maltreatment in each of these states, including high rates of youth-on-youth violence, sexual abuse,

overreliance on physical restraints and/or excessive use of isolation and solitary confinement.

■ Reports since 2011 have shown plainly that systemic maltreatment — in other words, compelling evidence that states were guilty of violating the constitutional rights of confined youth, with staff criminally liable in many cases — has continued in seven states where *No Place for Kids* identified clear evidence since 2000. These states include Arkansas, California, Florida, Nevada, New York, Ohio and Texas. In some cases, widespread maltreatment has persisted even years after states signed consent decrees agreeing to remedy problematic conditions within their facilities.

■ In seven other states (Indiana, Kansas, Maine, Maryland, Nebraska, New Jersey and New Mexico), substantial evidence of systemic maltreatment, but no concrete proof, has emerged since 2011.

■ All told since 2000, systemic maltreatment has been documented in the juvenile corrections facilities of 29 states, with substantial evidence of maltreatment in three other states.

New Evidence Regarding Widespread Sexual Abuse in Juvenile Facilities Nationwide

In 2013, the federal Bureau of Justice Statistics (BJS) published a national survey regarding sexual victimization of confined youth.

Since 2000 alone, systemic maltreatment has been documented in the juvenile corrections facilities of 29 states, with substantial evidence of maltreatment in three other states.

Conducted in 2012, the study revealed a continuing national epidemic of sexual abuse in state-funded juvenile corrections facilities. Nearly 10 percent of youth incarcerated in state-operated or state-funded juvenile corrections facilities reported being victimized sexually by staff or other youth in their facilities, and half of the victimized youth reported incidents involving physical force, threats or other forms of coercion *and* unwanted genital contact.

Growing Consensus That Disciplinary Isolation Harms Youth and Undermines Rehabilitation

While statistics on the use of solitary confinement in juvenile corrections facilities remain unavailable nationally, a number of new revelations have emerged showing egregious overuse of isolation, often in harsh circumstances and without constitutionally required due process protections. Meanwhile, youth advocates and mental health experts have focused increasing attention on the harmful effects of prolonged isolation on adolescents.

The new evidence presented in this report shows that while some states have tried to address maltreatment problems in their juvenile corrections facilities, either voluntarily or in compliance with court orders, these efforts

have often proved inadequate. Indeed, history makes clear that any facility where a large group of individuals are confined against their wishes, shut off from the wider world and utterly beholden to their keepers, is prone to maltreatment. Institutions for court-involved youth are at particularly grave risk, due to the impulsive behaviors of many residents, the low pay and limited training offered to staff in many facilities and the lack of political influence of confined youth and their families, most of whom are poor people of color. Finally, confining youth in large prison-like institutions built and operated on a punitive correctional model further exacerbates the dangers.

Fortunately, since the publication of *No Place for Kids*, more states have embraced reforms aimed at reducing confinement and several states have closed large juvenile facilities. However, even with this progress, tens of thousands of youth nationwide remain in custody on any given day. This fact, combined with a continuing stream of maltreatment revelations since 2011, highlights the urgent need to minimize the use of confinement for court-involved youth and abandon the traditional youth prison (or training school) model of incarceration for the limited number of youth who really do require confinement.



1.

Findings *from No Place for Kids on the Nature, Breadth and Extent of Maltreatment and Abuse in Juvenile Corrections Facilities*

No Place for Kids compiled extensive evidence showing that America's youth corrections institutions expose confined youth to unacceptable levels of danger and maltreatment. It documented widespread physical abuse and excessive use of force by facility staff; an epidemic of sexual abuse; rampant overreliance on isolation and restraints; unchecked youth-on-youth violence; and frequent violence against staff.

In its research for *No Place for Kids*, the Casey Foundation conducted a state-by-state scan of available news stories, investigative reports and government documents to uncover evidence of maltreatment in state-run or state-funded juvenile corrections facilities. The Foundation also provided the Youth Law Center with funding to compile an exhaustive list of lawsuits filed over conditions of confinement.

Based on this research, the Casey Foundation compiled a map of U.S. states documenting the incidence of what it termed "systemic or recurring maltreatment" of confined youth. The report used the following standard to identify maltreatment: "when clear evidence has emerged from federal investigations, class-action lawsuits or authoritative reports written by reputable media outlets or respected public or private

agencies showing that — at least at one particular time — one or more state-funded youth corrections facility repeatedly failed to protect youth from violence by staff or other youth, sexual assaults and/or excessive use of isolation or restraints." Applying this definition, *No Place for Kids* found that systemic or recurring maltreatment had been documented in 22 states plus the District of Columbia since 2000; in 33 states

plus the District of Columbia and Puerto Rico since 1990; and in 39 states plus the District of Columbia and Puerto Rico since 1970. The report also identified five states where evidence of maltreatment had emerged since 2000, but not enough to satisfy the above criteria.

No Place for Kids also found that maltreatment was pervasive, severe and deeply ingrained in several state juvenile corrections systems. For instance, a 2009 federal

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investigation in New York State found that staff in state juvenile corrections facilities “routinely used uncontrolled, unsafe applications of force” leading to “an alarming number of serious injuries to youth, including concussions, broken or knocked-out teeth, and spiral fractures.” In Ohio, a 2008 fact-finding report completed in connection with a class-action lawsuit found that “excessive force and the excessive use of isolation, some of it extraordinarily prolonged, is endemic” in the state youth corrections system. And a 2006 assessment of the California Youth Authority by a team of nationally recognized experts concluded: “This is a system that is broken almost everywhere you look...It is not just reform that is needed. Everything needs to be fixed.”

No Place for Kids noted that abuse and maltreatment were not omnipresent in juvenile correctional facilities nationwide. Some facilities provide humane care for confined youth, the report stated, while others fall short of this ideal but still protect youth from severe forms of abuse and maltreatment. Even in the worst facilities, many staff are dedicated and concerned for the well-being of their charges.



However, the first-ever nationally representative survey of youth in correctional care, published in 2010, confirmed that fear of violence and staff maltreatment remained widespread in America’s youth corrections facilities. Among youth in secure corrections facilities or camp programs, 42 percent said they were somewhat or very afraid of being physically attacked, while 45 percent reported that staff “use force when they don’t really need to,” and 30 percent said that staff place youth into solitary confinement or lock them up alone as discipline.

Heinous Abuses

In many instances, the severity of maltreatment documented in juvenile facilities has been chilling.

■ In 2001, the *Phoenix New Times* described the conditions inside an **Arizona** training school as follows: “The boys in the Nova cottage at Adobe Mountain School had been locked in their cells for six days. They had not been allowed to go to school or to the cafeteria or to chapel. No weekly phone calls. They had not showered, or washed their clothes. Some had been without a mattress on their metal bed frames for weeks. Left-over food and garbage sat on the floors of their cells; some boys banged on the doors, demanding to use the bathroom. A streak of dried urine ran under the door of one cell. Inside there was more urine and feces on the floor.”¹

■ In June 2003, a U.S. Justice Department investigation of two **Mississippi** training schools found widespread use of unconstitutionally abusive disciplinary practices, improper use and overuse of restraints and isolation, frequent staff-on-youth assaults and inappropriate use of OC [pepper] spray. The report described two common practices used at the facilities: “Hog-tying,” the investigation report explained, involved placing youth face down on the floor, handcuffing their arms behind their backs, shackling their legs together and then pulling the arm and leg restraints together with a belt or metal chain. “Pole-tying” involved shackling youths’ arms and legs to a pole in a public place while other youth perform exercises around them. As discipline for acting out or for exhibiting suicidal behavior, girls at one facility were often placed in “the dark room,” a locked windowless cell where they were stripped naked and left in complete darkness sometimes for days at a time. The room had no furniture — just an open drain in the floor that served as the toilet.²

■ On January 10, 2008, five male staff dressed in SWAT gear entered the room of a mentally ill 17-year-old, B.B., at the **Indiana** Juvenile Correctional Facility in Indianapolis. As part of a facility-wide search for drugs, weapons and other contraband, the men

ordered her to another cell and then instructed B.B. to remove all of her clothes for a strip search. B.B., who had been placed on suicide watch eight times during her three years in custody, refused. As documented on a videotape of the incident, B.B. sat quietly on the floor as the men repeated their demand that she take off her clothing. Then they pounced: pressing her face to the floor, they handcuffed B.B. and shackled her ankles. Using a seat-belt cutting tool, the men sheared off the girl's clothes, including her bra and underwear. The video ends with B.B. lying on the floor wearing nothing but her socks. According to a Justice Department report, "The only item between her and the dirty floor is a fragment of her torn underwear."³

■ In January 2006, just two hours after being admitted to a military-style correctional boot camp program in **Florida**, 14-year-old Martin Lee Anderson collapsed and stopped breathing. Videotape of the boy's initiation to the camp shows that after he pulled up just six laps into a mandatory one-mile run, at least seven boot camp staff surrounded the boy, shoved him against a pole, kned him and wrestled him to the ground. Several times the boy tried to stand up, but each time he fell back to the ground. Nonetheless, guards continued to strike him and apply painful pressure points, even after Anderson's body went limp. A nurse in white stood by watching idly. Gradually, staff realized that Anderson had lost consciousness. They tried unsuccessfully to revive him with ammonia before dialing 911. An ambulance arrived soon after to transport Anderson to a nearby hospital. The next day he was dead. An autopsy found that Anderson died of suffocation as guards covered his mouth and shoved ammonia capsules up his nose.⁴

2.

New Information *About Maltreatment* *in State-Funded Juvenile Corrections Facilities*

Since the fall of 2011, when *No Place for Kids* went to press, a substantial volume of new information has surfaced to shed further light on the nature and extent of abuse and maltreatment in America's juvenile corrections institutions. This information includes:

- Evidence of maltreatment in several states where no compelling recent evidence of pervasive or recurring maltreatment was identified in *No Place for Kids*.
- Reports documenting continuing problems in states where pervasive maltreatment had been uncovered since 2000.
- New surveys, research or other evidence regarding sexual victimization and the use of isolation in juvenile facilities.

A. Additional States with Proven Maltreatment

Since the publication of *No Place for Kids* nearly four years ago, conclusive new evidence of systemic and recurring maltreatment has emerged in seven additional states.

Colorado. *No Place for Kids* identified Colorado as a state where recurring or systemic maltreatment had been documented after 1990, but not since 2000. This designation was based on serious longstanding maltreatment (sexual assaults, physical abuse and excessive use of force by staff)

in a privately operated youth corrections facility, the High Plains Youth Center, which frequently housed youth referred from Colorado's juvenile courts prior to its closure in 1998. More recently, a series of news reports has documented troubling conditions in a state-run juvenile corrections facility, the Spring Creek Youth Services Center. In May 2014, a local school district that had been providing education services inside Spring Creek refused to renew its contract due to concerns over assaultive behavior.⁵ After initially denying any problems inside the facility, state officials acknowledged "a gamut of problems" at Spring Creek and released data showing that 139 assaults had occurred in the 80-bed facility over the prior year, including 16 violent attacks that caused or were intended to cause serious bodily injury.⁶ In 2013 alone, police were called to the facility for seven sexual assault incidents and 14 other assault incidents,⁷ and Spring Creek employees filed 60 workers' compensation claims.⁸ In July 2014, state leaders announced that they had restored order at Spring Creek after appointing a new director and instituting significant changes.⁹

However, the following month a major disturbance occurred at Spring Creek that involved at least seven youth and resulted in injuries to six staff members.¹⁰ In addition to these problems at Spring Creek, a legislative audit in August 2014 found that state-run and privately operated juvenile facilities throughout Colorado were prescribing enormous volumes of psychotropic medications to confined Colorado youth — often without a clear diagnosis or any parental consultation or consent.¹¹

Georgia. *No Place for Kids* identified Georgia as a state where recurring or systemic maltreatment had been documented after 1990, but not since 2000. Over the past three years, however, new evidence has emerged to show that maltreatment is once again widespread. In March 1998, the state of Georgia entered into a consent decree with the U.S. Department of Justice, agreeing to undertake substantial reforms to correct what federal authorities described as “egregious conditions” in the state’s secure juvenile facilities. Specifically, federal authorities cited problems with staff abuse, including excessive use of force; failure to protect youth from harm; and inadequate health, counseling, education and special education services. For the next decade, Georgia’s juvenile corrections agency remained under federal court supervision, and it reportedly made significant progress improving medical and mental health care and education services. However, in 2011, two years after federal supervision ended, a young man confined in the Georgia Department of Juvenile Justice’s Augusta Youth Development Campus was beaten to death by a fellow resident.¹² In the wake of the tragedy, the Georgia Bureau of Investigation and the Georgia Department of Juvenile Justice uncovered an array of problems in the Augusta

facility. Nine staff members were terminated for infractions that included sexual misconduct, initiating fights with youth, inappropriate use of physical restraints and negligence in protecting youth safety.¹³ Similar problems were identified in several other state facilities and resulted in more employee terminations.¹⁴ In 2013, a federal study found that Georgia facilities had the highest sexual abuse rates in the nation. In the wake of that study, the Department of Juvenile Justice revealed that more than 700 internal investigations inside Georgia youth facilities remained unresolved, including 141 cases of alleged sexual abuse or harassment.¹⁵

Idaho. In June 2012, 10 staff members of the Idaho Department of Juvenile Corrections filed a whistleblower lawsuit complaining of harassment and other retaliation after they raised complaints about problems in the operation of the state’s juvenile facilities. The lawsuit alleged that the department’s “security policies and practices are dangerous to both the staff and the juvenile offenders in its custody.” Specifically, the lawsuit cited inadequate staffing, practices allowing youth (including those with histories of violence) to be left unsupervised and engage in sexual activities, failure to confiscate contraband materials and misconduct by several staff members involving sexual relationships with confined youth.¹⁶ As of May 2015, that suit has not been resolved. However, a staff person at Idaho’s Nampa Juvenile Correction Center pleaded guilty in August 2013 to lewd sexual conduct with a 15-year-old facility resident.¹⁷ In a series of lawsuits filed in 2014, 11 other youth claimed that they had been sexually abused by staff at Nampa between 2008 and 2012. These lawsuits accused at least four other Nampa employees of sexual abuse and other inappropriate conduct,

and they claim that managers in the facility, including the former director, ignored warnings about the behavior of staff implicated in the abuse allegations. The former director resigned in 2012, and several other staff members have been fired as a result of the allegations.¹⁸ A former nurse at Nampa was arrested on sexual misconduct charges in May 2015.¹⁹

Illinois. In September 2012, the American Civil Liberties Union (ACLU) of Illinois filed suit against the Illinois Department of Juvenile Justice to protest conditions inside state juvenile correctional facilities, including excessive and unwarranted use of isolation, excessive use of force by facility staff and failure to protect youth from assaults by other youth.²⁰ Rather than contest the lawsuit, Illinois authorities agreed to settle the litigation quickly. In a December 2012 consent decree, the state agreed to have independent experts evaluate facility conditions related to isolation, safety, mental health treatment and other problem areas and to adopt remedial action plans based on the experts' findings.²¹ Previously, the John Howard Association of Illinois, a non-profit correctional reform advocacy group, had documented heavy use of solitary confinement in Illinois juvenile facilities. For instance, a 2008 monitoring report on the Illinois Youth Center in Harrisburg stated that until October 2006, youth placed into the facility's "reassignment unit" following a disciplinary event were held in their rooms for 23 hours per day and spent the remaining hour in a 12-by-20 cage. Youth were assigned to this unit for a minimum of three weeks. Youth in the Harrisburg facility were confined for 2,749 days in October 2006 — meaning that one of every four residents was held in seclusion every day.²² A September 2013 report submitted by an expert in the ACLU lawsuit concluded that

Illinois has taken significant strides to reduce the use of isolation since the state created a separate juvenile justice agency in 2006. (Previously, juvenile facilities were operated by the state's Department of Corrections.) However, the monitor found that state facilities continued to make "extensive and varied use" of solitary confinement. "The living conditions in the confinement units were often harsh and of substandard quality," the monitor reported. "Almost all of the youth that I interviewed...who had been assigned to these living units complained bitterly that the confinement units were cold and unsanitary. Youth in confinement status receive no schooling, no resource groups, and only about 90 minutes per day of recreation."²³ The John Howard Association's most recent monitoring report on the Illinois Youth Center in Kewanee found that facility youth were placed in isolation 1,170 times from July 2012 to July 2013, for an average of two and one-half days each.²⁴

Iowa. In July 2013, *The Des Moines Register* published the first in a series of articles detailing alarming use of solitary confinement and other maltreatment in the Iowa Juvenile Home, a state-run facility for behaviorally disturbed youth in custody of the state's child welfare and juvenile justice systems.²⁵ Specifically, youth in the facility, which holds a maximum of 57 residents, spent a total of 47,171 hours in seclusion from July 2012 through June 2013, an average of at least 70 hours per month for each young person.²⁶ Some residents spent months at a time in seclusion, allowed out of their 12-by-10 isolation cells for just one hour a day for hygiene and exercise. The cells had no furniture of any type — just concrete floors and walls, with a raised concrete slab for a bed, and a steel door. (Youth were given a thin mattress in the evening, returning

Conditions Inside the “Security Unit” of the Industrial Home for Youth, Salem, West Virginia

“The doors to the secure cells have a small window and a slot for youth to place their hands through when they are being handcuffed before the cell is opened. There is no natural light. The entire unit is dark. When they leave their cells, youth who have been placed on Loss of Privilege (LOP) status are handcuffed and shackled even though they are not leaving the secure area. Youth on LOP status shower in a shower area that has a secure grate. They do not get contact visits; they must visit with their parents via telephone and through a plexiglass partition.

“Youth spend most of the day locked into these cells. Youth on suicide watch and youth on LOP do not get hot meals or even plastic forks and spoons. They are forced to wear a Velcro wrap, eat cold ‘finger food.’ Daily these youth spend in excess of 23 hours locked in their cells. There is no organized therapeutic program.

“Youth spend days and weeks and even months in this unit. Youth placed on an Administrative Segregation can and do spend months in this unit (one youth had been locked up in this unit [for more than seven months]). Youth who are placed on a disciplinary status can spend five to ten or more days in this unit. Not surprisingly, these youth who are isolated for long periods of time often experience anger and agitation, cursing the guards, flooding their cells or in general being non-compliant. Such behavior — which should be anticipated — only results in more time in locked isolation.”

Source: DeMuro, P. (2012, September). *Solitary Confinement Issues: Preliminary Review of Conditions of Confinement of the West Virginia Industrial Home for Youth.*

it each morning.) Other news reports detailed several instances of physical abuse by facility staff, including a November 2012 incident in which security cameras reportedly captured video of two staff members dragging an overwrought girl down a hallway by her hands and feet. Staff then sat idly by while the girl slammed her head against a wall, after which a male staff member kicked the girl in her side and slammed her head against the wall.²⁷ In addition to the problems at the Iowa Juvenile Home, *The Des Moines Register* documented extensive use of isolation at the state's main juvenile correctional facility, the Eldora State Training School for Boys. In one 24-cell subunit within the 125-bed facility, residents spent more than 8,500 hours in seclusion in December 2012 — the equivalent of at least 11.5 hours every day for each young person.²⁸

Tennessee. In 1979, Tennessee settled a class-action lawsuit over excessive use of force, physical abuse, excessive discipline, sexual abuse and failure to protect youth from harm in its juvenile corrections facilities. Based on that case, *No Place for Kids* identified Tennessee as a state with documented maltreatment from 1970 to 1990, but not since. *No Place for Kids* also noted a number of troubling reports about Tennessee facilities since 2000, but none offered compelling proof of systemic maltreatment. Developments since 2010 leave no doubt that maltreatment has been systemic in at least one Tennessee facility and that troubling conditions prevail in other facilities as well. On September 1, 2014, 32 residents of the Woodland Hills Youth Development Center escaped. Two days later, after most but not all escapees had been captured, Woodland Hills residents rioted.²⁹ Then on September 26, 2014, Woodland Hills youth engineered another mass escape, this time involving 13 residents.³⁰ In the

aftermath of these disturbances, media reports documented widespread violence in the facility, some of it dating back years. Between January and early September 2014, there were 145 officially reported incidents of violence at Woodland Hills, which suffered with severe staff shortages. From July through September 2012, state records identified 102 officially reported incidents of violence there and police were called to the facility on 47 occasions. State records show that violence was also endemic at Mountain View Youth Development Center (67 assaults over those three months) and at the John S. Wilder Youth Development Center (90 assaults).³¹ In addition, two youths committed suicide at the Mountain View Youth Development Center in the summer of 2014.³²

West Virginia. In April 2012, a legal aid organization, Mountain State Justice, filed suit against the West Virginia Division of Juvenile Services over abusive conditions — particularly the excessive reliance on solitary confinement — inside the Industrial Home for Youth, the state's main training school.³³ In September 2012, Paul DeMuro, a nationally recognized expert in juvenile justice reform, filed a report on the Industrial Home, finding that facility staff “rely excessively and unnecessarily on the use of locked isolation.” Based on interviews conducted with youth in the facility, DeMuro reported, “It is clear that youth spend an inordinate amount of time locked in their cells. The use of isolation, particularly for youth, is harmful and counterproductive.” Youth on suicide watch, DeMuro noted, “are isolated, with little human contact and with no positive activity. There is no regular normal human interaction with staff or other youth. No counseling services are offered. There is no life-affirming activity. At times youth on suicide

watch are locked in a cell for several days before being assessed by a mental health specialist.”³⁴ In September 2012, the state signed a consent decree agreeing to improve counseling services and limit the use of solitary confinement.³⁵ Nine months later, a state judge ordered that the facility be closed entirely for youth in the juvenile justice system.³⁶ By September 2013, the Division of Juvenile Services had vacated the premises and the property has been converted for use as an adult prison.³⁷

Suggestive Evidence (But No Concrete Proof) of Maltreatment in Other States

Kansas. In July 2012, an audit conducted for the Kansas state legislature examined safety and security at the Kansas Juvenile Correctional Complex (KJCC), one of two remaining training schools operated by the state’s juvenile corrections agency, Juvenile Justice Authority. The audit found the facility “has not taken adequate steps to ensure the safety of juvenile offenders and staff.” Poor supervision by facility staff “has led to theft, injuries and sexual misconduct,” the audit found, and “failure to properly monitor juvenile offenders in the segregation unit has led to juveniles harming themselves.” The audit cited several instances in which safety was compromised by staff who propped open doors meant to remain locked, lost track of keys or failed to search bags and parcels brought into the facility by staff or guests as required by facility rules, allowing contraband to enter the facility. In at least one case, the contraband included a weapon — a handmade shank honed to a sharp point from an eyeglass lens.³⁸ While the audit of the KJCC facility was highly critical, it documented only a limited number of troubling incidents — not sufficient to qualify as “systemic or recurring maltreatment.”

Maine. *No Place for Kids* identified systemic maltreatment in Maine after 1990 and suggestive evidence but no proof since 2000, based on documentation of severe overuse of isolation and restraints in the late 1990s. One youth, who sued the state and eventually won a \$600,000 settlement, alleged that he had been tied down in restraints for as long as 49 hours while confined at the Maine Youth Center, and that he spent 87 days in solitary confinement. While reports of maltreatment continued after 2000, they were not enough to establish a pervasive pattern. Since 2011, the stream of troubling reports has continued. In July 2013, a youth at Mountain View suffered a broken jaw in what he claimed was one in a series of initiation fights organized by youth on his unit at the Mountain View Youth Development Center.³⁹ And the *Portland Press Herald* documented a spree of 23 violent incidents at the Long Creek Youth Development Center in the first two months of 2014, including several serious assaults on facility staff by confined youth.⁴⁰

Nebraska. In December 2013, a series of newspaper reports documented growing problems at Nebraska’s Youth Rehabilitation and Training Center in Kearney, including a sharp rise in both youth-on-youth and youth-on-staff assaults. Several facility workers suffered serious injuries in 2013 and at least eight workers resigned their posts in the final months of the year. State data show that 282 assaults were reported at Kearney in the first 11 months of 2013, while the facility’s confined population averaged about 150 youth per day.⁴¹ A detailed report on state youth corrections facilities prepared by the state’s Office of Probation Administration noted that many youth confined at Kearney feel “unsafe” due to high levels of violence and aggression among youth. The report called for increased staffing

levels, better staff training and improved rehabilitative programming, among other changes. A second report, prepared by the Nebraska Children's Commission, called for a new facility to separate violent youth from youth involved in lower-level offenses.⁴² Senator Brad Ashford, a member of the Children's Commission and chair of the state legislature's judiciary committee, labeled the situation "a crisis."⁴³

B. Recidivist States

In addition to the evidence showing maltreatment in states where *No Place for Kids* did not identify recent evidence of recurring or systemic problems, the past two years have revealed continuing maltreatment in the juvenile corrections facilities of several states where maltreatment was already documented in 2011. In some states, juvenile facility conditions have improved significantly through consent decrees or court-ordered corrective action plans, yet court monitors continue to find some degree of persisting maltreatment. In other states, the scope and seriousness of maltreatment remain severe and widespread. Following are updated details from states with continuing maltreatment problems.

Arkansas. Maltreatment in Arkansas juvenile facilities has been documented since the late 1990s, when the *Arkansas Democrat-Gazette* published a disturbing series of articles revealing heinous abuses. Entitled "Welcome to Hell," the series found that youth in state facilities were "routinely degraded; verbally, physically and sexually abused; hogtied; forced to sleep outside in freezing weather" and that "staff members have slugged children in the face and then refused to allow them to be treated by a nurse...and locked children naked in cells overnight after turning the air conditioning on high."⁴⁴ Subsequent

reports found that confined youth were being drugged inappropriately to control unruly behavior and subjected excessively to solitary confinement and harsh physical restraints. The state's largest facility, now called the Arkansas Juvenile Assessment and Treatment Center (AJATC), spent nearly 10 years under federal supervision after a federal investigation in 2002 found a number of unconstitutional conditions.

Unfortunately, indications of systemic maltreatment quickly reemerged at the AJATC facility after federal supervision ended in late 2012. In June 2014, the *Arkansas Democrat-Gazette* reported that 327 assaults had been documented at the facility in 2013, 98 percent more than in 2012 (165) and more than twice the number in any of the previous four years, even though the facility population has declined in recent years.⁴⁵ Another 135 assaults occurred in the first five months of 2014.⁴⁶ Subsequent news stories reported that on three occasions in early 2014, employees at AJATC had resigned or been fired after physically assaulting confined youth and that facility staff were inappropriately using physical restraints to subdue confined youth in many situations that could have been resolved with verbal counseling.⁴⁷ In August 2014, the Disability Rights Center of Arkansas released a monitoring report⁴⁸ finding that AJATC staff had been encouraging youths to assault other youths, rewarding them with candy bars.⁴⁹

California. Among all the states cited for systemic maltreatment in *No Place for Kids*, California has made perhaps the most significant progress to improve facility conditions since 2011. As detailed in *No Place for Kids*, California's juvenile corrections system has been in crisis for more than a decade. In 2003, an extensive safety review described California's system as "a very dangerous place," finding that "neither wards

nor staff feel safe in its facilities.” Meanwhile, hundreds of youth were being held in solitary confinement for 23 hours per day, with their remaining time locked in mechanical restraints or in a cage.⁵⁰ Though the state signed a consent decree in 2005 promising wholesale reforms, court monitors continued to document widespread violence and maltreatment for several more years. In fact, the violence rate inside state facilities did not decline from 2005 to 2011.⁵¹ Group disturbances and staff assaults also remained commonplace in 2011, and correctional staff continued to violate new state rules by confining youth to their cells for more than 21 hours per day.⁵²

By 2013, however, court monitors were citing significant progress. When safety expert Barry Krisberg interviewed 99 confined youth in mid-2013, he found that “none of the youth expressed any significant safety concern.”⁵³ In October 2013, the special master in the ongoing litigation noted “an encouraging trend of decreasing use of force” in all three of the state’s remaining juvenile corrections facilities, and she lauded the state for a “vast improvement in the climate at the facilities as a result of the reform effort.”⁵⁴ Even with this progress, court papers make clear that maltreatment has remained commonplace in one of the three remaining state institutions, the Ventura Youth Correctional Facility. There (and to a lesser extent in a second facility), monitors found that staff frequently used force (physical restraints and/or chemical agents) against individual non-compliant youths in situations that did not involve altercations with other youth or threats of violence against staff. Also, Ventura staff continued to frequently employ pepper spray against youths with mental health conditions.⁵⁵ Both practices violate established best practice, and

both were sharply restricted in the Safety and Welfare Remedial Plan adopted in conjunction with the consent decree settling the conditions-of-confinement lawsuit.

Florida. In the state-by-state summary of maltreatment in juvenile corrections facilities released at the time of *No Place for Kids*’ publication, the Casey Foundation reported that “Florida juvenile corrections facilities have seen a large number of tragedies and abuses in recent years, including the deaths of nine confined youth.” The *Orlando Sentinel* reported that state Department of Juvenile Justice staff were responsible for 661 verified cases of child abuse from 1994 to 2004 and in 2010 the *St. Petersburg Times* published a harrowing six-part series detailing decades of abuses at the state’s Arthur G. Dozier School for Boys.

Since 2011, the stream of troubling reports about Florida facilities has continued both in state-run facilities and in Florida’s sprawling network of privately run facilities. In December 2011, the U.S. Justice Department released an investigative report finding that youth confined in the Arthur G. Dozier School for Boys and the nearby Jackson Juvenile Offender Center “were subjected to conditions that placed them at serious risk of avoidable harm in violation of their rights protected by the Constitution of the United States.” The Justice Department report cited evidence that facility staff were engaged in “systemic, egregious and dangerous practices” and that these problems were “exacerbated by a lack of accountability and controls” from state officials.⁵⁶ (The state closed both facilities in May 2011.)

Meanwhile, serious problems have been reported in at least three private facilities housing youth committed to state custody. An August 2013 riot

at the Avon Park Youth Academy destroyed 18 of the facility's 20 buildings and resulted in seven youth being taken to the emergency room, one with a broken leg.⁵⁷ That same month, four staff were injured when a major disturbance broke out at the Gulf Coast Youth Academy.⁵⁸ The following month a riot erupted at the Gulf Coast facility, resulting in the arrest of eight youth and the firing of two employees.⁵⁹ Prior to its closure in September 2012, the Thompson Youth Academy in Broward County was engulfed in repeated controversies, including dozens of 911 calls seeking treatment for youth injured in assaults, investigations into alleged child abuse and other maltreatment-related emergencies;⁶⁰ a lawsuit alleging sexual abuse and other maltreatment by facility staff that was settled for an undisclosed sum;⁶¹ and the resignation of the facility's director following allegations that he was involved in the sexual abuse of confined youth.⁶²

Finally, in 2011, the *Palm Beach Post* reported that Florida juvenile facilities were purchasing massive quantities of antipsychotic drugs — 326,000 pills in 2007 alone — and that the state had no system to track prescriptions or parental consent.⁶³

Nevada. In 2002, a U.S. Justice Department investigation revealed widespread use of excessive force against youth confined in the Nevada Youth Training Center, including incidents involving facility staff “punching youths in the chest, kicking their legs, grabbing shirts and shoving youths against lockers and walls, ‘dipping’ or throwing youths to the floor, slapping youths in the face, smashing youths’ heads in doors and pulling youths from their beds to the floor.” In 2004, the state signed a Memorandum of Understanding pledging to reduce the use of force by staff, enhance its grievance process for youth, increase staffing levels, improve training, limit the use of isolation and expand mental

health treatment. After four years, the Justice Department approved an end to its oversight of the facility. Since then, however, violence, maltreatment and other safety concerns have emerged at several Nevada facilities. In 2014, the chief juvenile judge in Clark County (Las Vegas) ordered all local youth removed from the Nevada Youth Training Center after learning that staff in the facility had been hog-tying confined youth.⁶⁴ Hog-tying was reported at a second facility as well, the co-educational Caliente Youth Center.⁶⁵ In December 2014 and March 2015, riots broke out at the Silver State Academy, a privately operated facility serving youth from Nevada and out of state. In one incident, which began with a fight among confined youth, two buildings were set on fire, four staff were injured and 10 youth escaped the facility. The incident drew 70 emergency response personnel.⁶⁶ Also in March 2015, Nevada's Department of Children and Family Services closed the Red Rock Academy, a maximum-security facility, after the private contractor hired to operate the facility “repeatedly ran afoul of safety and civil rights requirements.”⁶⁷

New York. Led by a reform-minded commissioner, New York State's juvenile corrections agency, the Office of Children and Family Services, has dramatically reduced the confined juvenile population since 2008, closing 14 state facilities and embarking on a new “Close to Home” program that is allowing hundreds of New York City youth to remain under the custody of the city's Administration for Children's Services, rather than being relocated to state facilities upstate. However, state efforts to improve safety for youth in the remaining facilities have not proven effective. In fact, assaults and injuries in the facilities have risen sharply. In 2012, 337 assaults took place in the state's four remaining secure custody facilities, three

times the number that occurred in any of the previous four years.⁶⁸ As a result of the spike in facility violence, worker compensation claims also ballooned in 2012, as did medical costs to treat youth. Again in 2013, news reports documented a number of violent disturbances in state facilities.⁶⁹ In December 2013, the state settled a longstanding private lawsuit over conditions filed by current and former wards. While the state did not admit any wrongdoing in the settlement, it agreed to pay \$500,000 in damages to the plaintiff youth, plus \$1 million in legal fees, and it committed to instituting a wide range of reforms aimed at improving mental health care for confined youth and limiting the use of force by correctional staff.⁷⁰

Ohio. Like New York, state juvenile corrections leaders in Ohio have embraced many promising reforms that in recent years have dramatically reduced the juvenile population incarcerated in state facilities. However, though two 2008 consent decrees (signed with the U.S. Department of Justice in *U.S. v. Strickland* and with plaintiffs in the private lawsuit, *S.H. v. Stickrath*) obligated the state to undertake a wide range of reforms, conditions inside the institutions remained troubling. In December 2011, Ohio Youth Services Director Harvey Reed signed a settlement agreement pledging to abandon practices that led to the pepper-spraying of teens in Ohio's Scioto and Circleville Juvenile Correctional facilities earlier that year. An inquiry by national experts found that guards' use of pepper spray was not justified in any of the 11 instances studied. "None of the youth were armed; none were barricaded; none were physically violent; none were engaged in targeted aggressive movement toward staff; and none were engaged in striking, grabbing, pushing or punching of staff," their report found.⁷¹ In October 2012, the plaintiffs in the *S.H. v. Stickrath* case (since renamed *S.H.*

v. Reed) filed a motion documenting continuing maltreatment of youth held in disciplinary units in Ohio's Scioto Juvenile Correctional Facility, including overuse of seclusion.⁷² These and other continuing problems were substantiated by the court-appointed special master in *S.H. v. Reed* in December 2012.⁷³ A month later, the state signed updated consent decrees agreeing to limit isolation, improve mental health treatment and stop placing mentally ill youth into disciplinary units.⁷⁴ Yet the situation in the facilities saw little change until the U.S. Justice Department joined the lawsuit in March 2014.

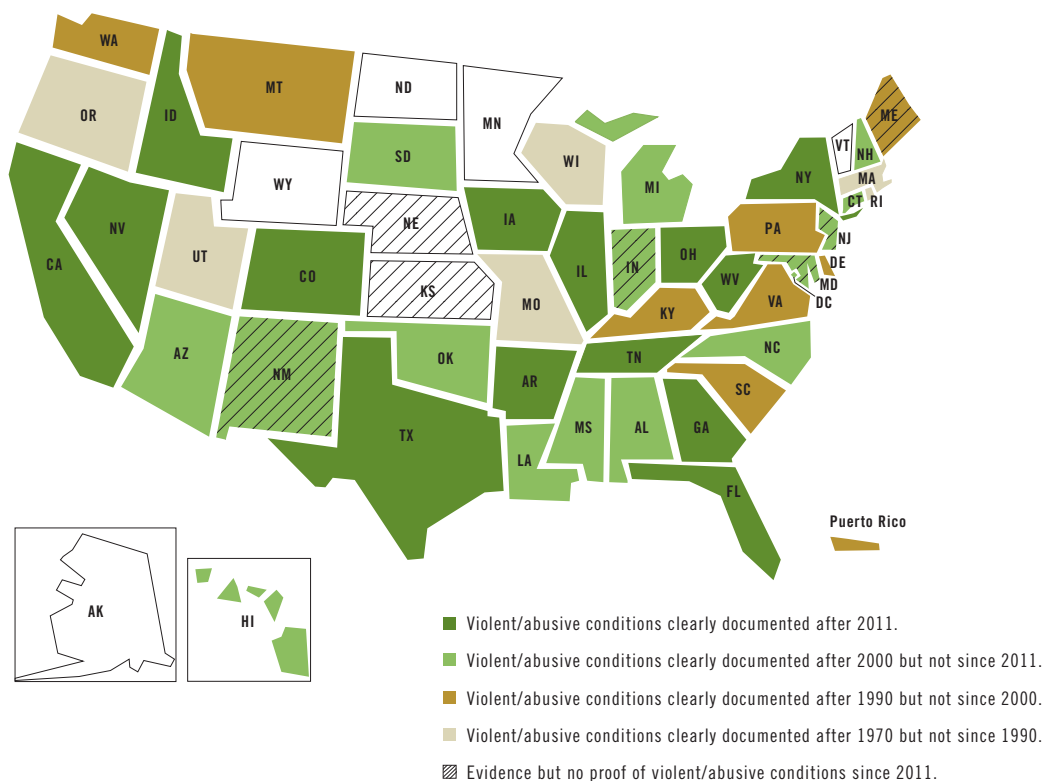
Texas. In June 2007, Texas enacted a major juvenile justice reform bill intended, in the words of Governor Rick Perry, to "change the broken culture at the youth commission so that it can fulfill its mission of rehabilitating troubled youth."⁷⁵ Since then, 10 state facilities have been shuttered and the population in state correctional facilities has plummeted by over 70 percent.⁷⁶ However, new evidence shows that the remaining facilities are plagued with serious continuing problems. *The Texas Tribune* reported in February 2012 that the number of youth injured in assaults at the Giddings State School quadrupled from 2007 to 2011 and the number of times staff used pepper spray on youth tripled.⁷⁷ State-wide in all facilities, the rate of youth-on-youth assaults also tripled from 2007 to 2011. In May 2013, a major study by the University of Texas found that violence remained commonplace in Texas facilities. In 2012, the study reported, more than 7,000 violent incidents occurred in state facilities, including more than 1,700 that resulted in injuries.⁷⁸ In late 2013, the *Austin American-Statesman* uncovered documents and video footage showing that guards in another state facility (McLennan) regularly fought with teens, slammed them on concrete floors, pinned them to the ground and punched them.⁷⁹

In addition, evidence of continuing maltreatment has also emerged in four additional states where maltreatment was clearly documented after 2000 in *No Place for Kids* — Indiana, Maryland, New Jersey and New Mexico. However, the new evidence does not amount to conclusive proof of systemic maltreatment since 2011 in these states.

Adding all of the states with newfound evidence to the findings of *No Place for Kids*, we now have conclusive evidence of systemic maltreatment in:

- 14 states since 2011 (plus seven additional states with some evidence of systemic maltreatment);
- 29 states, along with the District of Columbia, since 2000 (plus three additional states with some evidence of systemic maltreatment);
- 37 states, along with the District of Columbia and Puerto Rico, since 1990; and
- 43 states, along with the District of Columbia and Puerto Rico, since 1970.

SYSTEMIC OR RECURRING MALTREATMENT IN JUVENILE CORRECTIONS FACILITIES IN THE STATES: 1970 TO PRESENT



For this map, “systemic or recurring maltreatment” is identified when clear evidence has emerged from federal investigations, class-action lawsuits or authoritative reports written by reputable media outlets or respected public or private agencies showing that — at least at one particular time — one or more state-funded youth corrections facilities repeatedly failed to protect youth from violence by staff or other youth, sexual assaults and/or excessive use of isolation or restraints. “Evidence but no proof” is indicated when credible reports of maltreatment have emerged, but not enough to satisfy the above criteria.

For more information, visit www.aecf.org.

Maltreatment Also Rife in Detention Centers and Other Youth Facilities

While this update report (like *No Place for Kids*) focuses on state-funded juvenile corrections facilities, maltreatment is also disturbingly commonplace in detention centers and in other types of institutions housing court-involved or troubled youth. For instance, the spring and summer of 2014 saw a spate of troubling revelations about treatment of youth in juvenile detention centers — the locked institutions, most often locally operated, where youth may be confined after arrest while pending court hearings or awaiting placement to a correctional or treatment facility:

■ In **San Diego**, a federal lawsuit was filed in July 2014 to limit the use of pepper spray against youth confined in county detention facilities.⁸⁰ Earlier news reports revealed that youth in the detention centers (and some in local juvenile corrections institutions) were subjected to pepper spray 461 times in 2011 and 414 times in 2012, and that custodial staff were “using pepper spray routinely and indiscriminately as a first resort to gain compliance rather than only as a last resort” to quell even minor misbehavior. Despite the pain pepper spray inflicts (intense burning, swelling, redness, occasionally blistering and exacerbation of allergic reactions) and the serious risk of complications for youth with respiratory or mental health problems, San Diego detention staff used it on youth at risk of suicide; youth with respiratory, cardiovascular and skin problems; and youth being treated with psychotropic medications.⁸¹

■ In **Arkansas**, staff at the Yell County Juvenile Detention Center were ordered in September 2014 to end their practice of restraining youth with an unconventional device, called the WRAP, plus a motorcycle helmet covered in duct tape (covering the face shield) and decorated with a cartoonish, hand-drawn face. Youth restrained in this manner were made to sit upright, sometimes for hours at a time, with their legs immobilized and arms handcuffed behind their backs in near-total darkness. In a letter to Yell County, the director of Arkansas’s Division of Youth Services wrote, “The WRAP system has no known therapeutic uses. As modified by the Yell County JDC, the system violates

the recommended guidelines of the manufacturers, exposes youth to ridicule and humiliation and presents serious risk of harm to youth in your care.”⁸² The state also urged three other detention centers to end their use of the WRAP restraint device.⁸³

■ In September 2014, the Multi-County Detention Center in northern **Ohio** was sued in federal court, accused of not only isolating youth in solitary confinement, sometimes for weeks on end, but also keeping the lockdown cells at dangerously low temperatures while withholding blankets or warm clothing. As a result, detained youth suffered symptoms of frostbite on their fingers and toes, as well as hypothermia.⁸⁴

Meanwhile, a host of research finds that youth incarcerated in adult jails and prisons are at even greater risk for violence and abuse than youth housed in juvenile facilities,⁸⁵ and maltreatment is also widely reported in group homes, wilderness camps and other residential facilities for youth involved in the juvenile justice, mental health and child welfare systems.⁸⁶

C. New Evidence of and Attention to Maltreatment

In addition to the many recent reports documenting maltreatment in specific states and facilities, new evidence has emerged since 2011 to further our understanding regarding the scope and implications of two particular forms of maltreatment: sexual victimization of confined youth and placement of youth into solitary confinement.

More Information on Widespread Sexual Abuse in Juvenile Facilities. In 2013, the federal Bureau of Justice Statistics published the second-ever national survey regarding sexual victimization of confined youth, based on a questionnaire completed in 2012 by a representative sample of nearly 9,000 youth confined in state-operated or state-funded juvenile corrections facilities. The study found that 9.5 percent of incarcerated youth reported being victimized sexually by staff or other youth in their facilities during the prior year. Half of the victimized youth reported incidents involving physical force, threats or other forms of coercion *and* unwanted genital contact. While the sexual victimization rate (9.5 percent) was marginally lower in 2012 than in an earlier survey conducted in 2008–09, the results indicated a continuing national epidemic of sexual abuse in state-funded juvenile corrections facilities.⁸⁷

More specifically, the latest survey found that:

- 7.7 percent of confined youth reported one or more sexual victimization incidents involving facility staff and 2.5 percent reported at least one incident involving non-consensual sexual contact with other youth. (Some youth — 0.7 percent — reported being victimized sexually by both youth and staff.)

- Among youth who were victims of staff sexual misconduct, roughly six of every seven reported multiple incidents and one in every five reported 11 or more incidents. In the vast majority of cases (89 percent), staff sexual misconduct involved female staff with male youth and in many cases these incidents involved physical force or the threat of force (20 percent), offers of protection from harm (12 percent) and/or gifts of alcohol or drugs in exchange for sex (22 percent).

- Among youth who reported non-consensual sexual contact with other youth, 68 percent reported the use or threat of force, 70 percent reported two or more incidents, 37 percent reported two or more perpetrators and 18 percent suffered physical injuries.

The survey found that sexual victimization rates were two to three times higher in large facilities (100 or more youth) than in small facilities (25 or fewer youth). Higher rates of sexual victimization were also found in facilities where youth reported fewer positive opinions about facility staff and average rates were higher in state-operated than in privately operated facilities.

The national BJS sexual victimization surveys were mandated by a federal law enacted in 2003, the Prison Rape Elimination Act (PREA). The law also required the U.S. Department of Justice to issue regulations specifying the steps that adult and juvenile correctional facilities must take to prevent, detect and address sexual victimization. The required protocols for juvenile facilities, issued in 2012, include screening and training staff; eliminating pat downs and strip searches by staff of the opposite sex; facility-wide video monitoring; mandatory reporting and thorough investigation of suspected sexual abuse; and minimum staffing ratios to ensure

adequate supervision. Though most of the PREA guidelines involve common-sense protections to shield youth from sexual abuse, audit studies revealed that adhering to the law will require substantial investments in many states. In all, the Justice Department estimates that bringing juvenile facilities into compliance with the law — ensuring adequate protections against sexual victimization of confined youth — would cost an estimated \$2 billion over 15 years above what states are currently spending.⁸⁸

Unfortunately, it is by no means clear that states will implement the mandated protections. To encourage compliance, the law provides that states not conforming to the required protocols will lose 5 percent of all funds they receive from the U.S. Department of Justice grant programs. However, these financial penalties will not begin until 2017 and even then many observers expect that the Justice Department will extend the deadline and/or disperse the funds to non-compliant states, provided they use the money toward implementing PREA requirements.⁸⁹

Effective action to end the sexual abuse epidemic for confined teens remains a distant goal in many parts of the nation.

Continuing Overreliance on Isolation in Juvenile Facilities Despite Growing Consensus That It's Harmful and Counterproductive. In the nearly four years since the publication of *No Place for Kids*, a stream of evidence has emerged showing that excessive, unwarranted and counterproductive isolation of confined youth remains widespread in many correctional facilities.

Some of the most egregious revelations have concerned youth tried and punished in the adult justice system. In Texas, a 2012 report found that

youth held in many county jails were confined in their cells for 23 hours or more every day, often for months on end, and the vast majority of the jails offered youth less than five hours per week of schooling (or lacked an educational program entirely).⁹⁰ In New York City, a September 2013 report revealed that 140 teenagers were being held in solitary confinement in July 2013 inside the vast Rikers Island correctional complex, three-fourths of them mentally ill.⁹¹ A second report detailed the cases of three adolescents (two diagnosed with bipolar disorder, one with depression among other symptoms) who had spent at least 200 days in punitive isolation, locked in their cells for 23 hours per day and in an individual cage for the remaining hour, with no education services and infrequent mental health counseling.⁹²

Considerable new evidence has also emerged documenting the continuing problematic use of solitary confinement in juvenile facilities. As noted earlier in this report, alarming and/or inappropriate overreliance on isolation has been documented recently in Illinois, Iowa and West Virginia. Additionally, new evidence of overreliance on isolation has been documented in several other states.

■ In Texas, an in-depth independent evaluation of state youth facilities in 2013 found that correctional staff rely on isolation “to an extraordinary extent.” During a 12-week period in mid-2012, youth in state facilities were referred to so-called “security units” on more than 12,000 occasions. On average, the study found, each confined youth is referred to the security units 48 times during his or her period of custody. While in these units, youth are housed in individual locked cells: just one in five receives any counseling in the lock-up units and fewer than half

receive any education services.⁹³ Meanwhile, youth confined in county-level juvenile facilities in Texas (detention centers and local corrections institutions) were secluded on 37,000 occasions in 2011.⁹⁴

■ In New Jersey, state officials agreed to pay \$400,000 in 2013 to settle a lawsuit over excessive use of solitary confinement in state juvenile correctional facilities.⁹⁵ Despite many requests, the state has released no data about the number of youth placed in solitary confinement or the duration of their isolation. However, the director of a legal aid project for incarcerated youth in New Jersey recently reported that roughly 120 of 200 clients had spent time in solitary confinement. In February 2014, New Jersey's juvenile corrections agency rejected a petition from the ACLU and eight other advocacy organizations to ban the use of isolation as punishment.⁹⁶

■ In Ohio, the continuing use of solitary confinement as a routine practice has been the subject of litigation for nearly a decade. In March 2014, six years after filing suit over excessive isolation and other problematic conditions in Ohio facilities, the U.S. Justice Department filed a new court motion demanding that state facilities desist from the practice of isolating mentally ill youth. (See account on page 27.)

In 2012, the Council of Juvenile Correctional Administrators (CJCA), which has denounced the extended use of isolation as “detrimental and counterproductive,” reported that the 162 facilities participating in its highly regarded Performance-based Standards (PbS) project in 29 states nationwide had substantially reduced the average length of time youth spent in isolation over the prior four years. However, the CJCA report still found that 38 percent of youth in PbS facilities were placed in isolation.⁹⁷

Continuing problematic use of solitary confinement for youth in correctional settings is hardly new. What has been groundbreaking over the past three-plus years is a flurry of attention to the issue, including a number of high-profile statements and publications advocating reform:

April 2012: The American Academy of Child and Adolescent Psychiatry issued a statement opposing the use of solitary confinement in juvenile correctional facilities. “The potential psychiatric consequences of prolonged solitary confinement are well recognized and include depression, anxiety and psychosis,” the statement declared. “Due to their developmental vulnerability, juvenile offenders are at particular risk of such adverse reactions.”⁹⁸

June 2012: In its final regulations for implementation of the Prison Rape Elimination Act, the U.S. Department of Justice included a number of limitations on the use of isolation for youth in correctional settings as well as protections for youth when they are isolated. The regulations also encouraged correctional authorities “to minimize their reliance on isolation for juveniles to the greatest extent possible.”⁹⁹

October 2012: Human Rights Watch and the ACLU jointly released a study, *Growing Up Locked Down*, which documented the pervasive isolation of underage youth in adult jails and prisons nationwide, often for months on end, and frequently in inhumane conditions.¹⁰⁰

December 2012: The National Task Force on Children Exposed to Violence, convened by U.S. Attorney General Eric Holder, released a report sharply criticizing the widespread reliance on solitary confinement of youth in juvenile and adult correctional facilities and decrying the “devastating effects” isolation can

have on youth with past histories of abuse or other types of trauma.¹⁰¹

July 2013: Robert Listenbee, administrator of the U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP), wrote a letter to the ACLU confirming OJJDP's official position that "isolation of children is dangerous and inconsistent with best practices and that excessive isolation can constitute cruel and inhumane punishment."¹⁰²

November 2013: The ACLU released a new report, *Alone and Afraid*, examining the overuse of isolation in juvenile corrections facilities. The report detailed serious psychological, physical and developmental harm that isolation can inflict on youth, and it outlined the legal case for banning disciplinary isolation in juvenile facilities.¹⁰³

These statements and publications follow a string of court rulings finding that arbitrary and extended use of punitive isolation for young people violates the constitutional ban on cruel and unusual punishment. The evidence is overwhelming that solitary confinement is dangerous and counterproductive for youth rehabilitation, and it is especially inappropriate for youth with mental illness or histories of abuse/trauma and those at risk of suicide.¹⁰⁴

In response to this flood of attention, or in efforts to settle court cases alleging unconstitutional overreliance on solitary confinement, a handful of states have taken action since 2011 to limit the use of isolation for court-involved youth and legislative proposals are pending in several other states.

In the face of litigation, both Illinois¹⁰⁵ and West Virginia¹⁰⁶ have imposed new rules since 2011 prohibiting the disciplinary use of isolation in

juvenile facilities. Nevada enacted legislation in 2013 restricting the use of isolation.¹⁰⁷ And, in response to a federal lawsuit in March 2014, Ohio agreed to sharply limit the use of isolation. (See account on page 27.) Several other states — including Alaska, Connecticut, Maine, Massachusetts and Oklahoma — have also imposed restrictions on solitary confinement for youth in correctional settings.¹⁰⁸ In addition, court settlements have limited the isolation of youth in adult facilities in Mississippi and Montana since 2011, and in 2013 New York State announced new limits on isolation of youth incarcerated in state prisons.¹⁰⁹ (These new rules did not apply to the Rikers Island correctional complex, which is operated by New York City. But in September 2014, after the U.S. Justice Department released a 79-page report detailing wholesale abuses at Rikers,¹¹⁰ New York City agreed to abandon the use of isolation for prisoners younger than 18.¹¹¹) In several other states — including California, Nebraska, New Hampshire and Texas — legislation was introduced in 2013 proposing to limit the use of isolation in juvenile facilities, but did not pass.¹¹²

Despite this growing attention to the issue and encouraging reforms implemented in some states, isolation remains common practice in juvenile facilities throughout much of the country. As yet, there is little reason to expect that excessive use of solitary confinement will be significantly curtailed nationwide in the foreseeable future.

Ohio — A Case Study in Excessive Solitary Confinement

In December 2007, an expert assigned to examine the Ohio Department of Youth Services (DYS) as part of a private lawsuit over conditions of confinement declared that the state’s “extended — at times months on end — use of isolation (i.e., segregation) must be immediately revisited and dramatically changed.” In May 2008, the state settled the lawsuit, agreeing to a wide range of reforms, including limits on the use of solitary confinement. However, a year later the state instituted new rules that quickly tripled the number of hours youth spent in isolation from 18,500 hours to 57,000 per month.¹¹³

In the years that followed, the situation saw little if any improvement. In October 2012, the plaintiffs in the private conditions-of-confinement lawsuit filed a motion protesting the continued isolation of youth, most of them with serious mental health needs, in the so-called “PROGRESS Units” at the state’s Scioto Juvenile Correctional Facility. Citing monitor reports, official state data and interviews with youth, the motion alleged that youth held in these disciplinary units were routinely denied education services and other mental health treatment and confined in their cells up to 24 hours per day.¹¹⁴

As part of the motion, the plaintiffs submitted a statement by psychiatrist Stuart Grassian, a leading authority on solitary confinement, who had reviewed the files of six youth. Grassian described the conditions in the PROGRESS Units as “extravagantly harsh.” Youth were held in “barren concrete boxes, with solid steel doors and a cuff port, no different from the solitary confinement cells in adult prisons,” Grassian wrote, where “they spend day after day, month after month, virtually continuously.”¹¹⁵

From the case files, Grassian found that “this wholesale use of solitary confinement is causing severe, possibly permanent, harm to the youths so confined....Every one of [the six youth] demonstrated the destructive impact of their confinement at ODYS. Youths arrive with severe psychiatric and cognitive burdens, but they arrive with some hope, some willingness to engage. Placing this exquisitely vulnerable group of youngsters in harsh conditions of solitary confinement basically dooms them. They become more violent, more out of control, more rigidly locked into their ‘evil side.’”¹¹⁶

In November 2013, DYS announced that it would be closing its Scioto facility and disbanding the PROGRESS Units. However, that same month a state correctional watchdog agency released data showing that isolation remained rampant throughout the DYS system. During 2012, confined youth in DYS facilities spent nearly 200,000 hours in seclusion, an average of 358 hours per young person per year — no less than in 2009.¹¹⁷

In February 2014, plaintiffs in the private lawsuit filed a motion protesting the continuing heavy use of isolation for youth with mental health illnesses. The following month, the U.S. Justice Department filed a similar motion seeking a temporary restraining order that would strictly limit isolation for mentally ill youth. “The State has systematically violated the substantive due process rights of boys with mental health disorders,” the Justice Department stated. “The State punishes the boys with seclusion (i.e., solitary confinement) for days on end, often also depriving them of education, exercise, programming and crucial mental health care.”¹¹⁸

In this recent filing against Ohio, the Justice Department declared that, “As poor as the State’s track record has been, its overreliance on seclusion is getting worse, not better.” Days later, *The Columbus Dispatch* confirmed this assessment in a story reporting new data obtained through a public records request. Total hours of isolation in DYS facilities increased during 2013, even as facility populations continued a long-term decline. The average hours of isolation in DYS facilities rose to 453 hours for each confined young person, the highest in recent memory.¹¹⁹

Finally, in May 2014, Ohio signed a new consent decree pledging to “dramatically reduce, and eventually eliminate, its use of seclusion on young people in its custody.” In the short term, the settlement requires Ohio to “eliminate the use of disciplinary seclusion on youth with mental health needs, except for the most serious offenses, limit the amount and duration of disciplinary seclusion in the limited circumstances when it is permissible,” and provide confined young people with individualized mental health treatment to prevent and address the conditions and behaviors that lead to seclusion.¹²⁰ In February 2015, the Ohio Correctional Institution Inspection Committee reported that the use of seclusion decreased by two-thirds in 2014 (from 459 hours per youth per year in 2013 to 153 hours in 2014).¹²¹

Conclusion

The troubling evidence presented in this report should remove any remaining doubt that large conventional juvenile corrections facilities — or plainly stated, youth prisons — are inherently prone to abuse. Given public officials' inability to prevent maltreatment, or even to clean up youth prisons where inhumane conditions are revealed, it seems difficult to argue that confinement in these institutions offers a safe approach for rehabilitating delinquent youth.

Given this record on maltreatment, the juvenile justice field faces two pressing challenges.

First, juvenile justice systems nationwide must make every effort to eliminate inappropriate or unnecessary reliance on confinement in response to adolescent misbehavior and law-breaking. Even after recent reductions in the population of confined youth nationwide, a large majority of youth held in residential custody by delinquency courts are adjudicated for non-violent and/or lower-level offenses. Meanwhile, the recidivism results of juvenile corrections facilities are almost uniformly poor, and compelling evidence finds that community-based supervision, treatment and youth development programs achieve equal

or better results at a fraction of the cost. Given these realities, juvenile confinement rates remain far too high.

Second, state juvenile corrections agencies must abandon the large training school model and undertake aggressive efforts to reform, reinvent and/or replace their facilities to ensure safe, healthy and therapeutic care for the small segment of the youth population who truly require confinement.

Removing a child from his or her home is a grave decision. It involves breaking apart the family and temporarily severing the rights and authority of parents. It denies children their freedom, and it robs them of the opportunity to participate in many important rites of passage associated with adolescence — attending high school, participating in after-school and community activities, dating, learning to drive, getting a first job and exercising increasing autonomy more generally. Given these consequences, children should be removed from home only rarely — and they should never be confined in environments fraught with danger, violence and abuse.

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